DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: March 10, 2015

From: Interim Under Secretary for Health

Subj: Summary of Phase One Clinical Review Findings, Tomah, WI

To: Secretary

Thru: Deputy Secretary

1. In January 2015 you directed me to lead a comprehensive review of medication prescription practices at the Tomah VA Medical Center (VAMC) and to report back in 30 days.

2. On January 23, 2015, I convened a clinical review team consisting of nine clinicians and other subject matter experts from across VHA to " assess the practice patterns, controlled substance prescribing habits, and administrative interactions with subordinates and clinical leadership as related to prescribing practices" at the Tomah VAMC.

3. The team submitted a report summarizing its findings on March 4, 2015. Based on a review of computerized medical records of eighteen (18) patients, the team found unsafe clinical practices at the Tomah VAMC in areas such as pain management and psychiatric care. More specifically, six of 18 cases revealed that patient harm (examples of falls) that could be at least partially attributable to prescribing practices (multiple CNS depressants and/or high dose opioids); nine of 18 lacked evidence of changing the treatment plan in the face of aberrant behaviors; and twelve of 18 demonstrated extensive use of opioids and benzodiazepines.

4. The team made specific findings relating to overall opioid utilization at Tomah and other VHA facilities, noting that 11.5% of Tomah patients receive opioid medications as compared to 14.6% of patients VA wide. The team also found that Tomah patients were 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day (1.08% vs. 0.42%), and were also more likely than the national average to be prescribed opioid doses between 200-300 morphine equivalents per day (1.53% vs. 1.2%). With respect to the use of benzodiazepines and opioids concomitantly, which is discouraged due to risks of complications, the team found that Tomah VAMC was almost double the national average (20.4% vs. 11.7%).

5. The team also found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VHA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. That additional review is now ongoing.

Carolyn M. Clancy, MD